

MEDICAL ASSISTANCE ADMINISTRATION



Prosthetic and Orthotic Devices

Billing Instructions

Chapter 388-543 WAC

September 2001

About this publication

This publication supersedes all previous MAA <u>Prosthetic and Orthotic Devices Billing Instructions.</u>

Published by the Medical Assistance Administration Washington State Department of Social and Health Services September 2001

Received too many billing instructions? Too few? Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Provider Enrollment Unit (866) 545-0544

Where do I send my claims?

Hard Copy Claims:

Division of Program Support PO Box 9247 Olympia WA 98507-9247

Magnetic Tapes/Floppy Disks:

Division of Program Support Claims Control PO Box 45560 Olympia, WA 98504-5560

How do I request prior authorization?

All authorization issues, questions or comments should be addressed to:

Write/Call:

Division of Health Services Quality Support Quality Utilization Section Durable Medical Equipment PO Box 45506 Olympia, WA 98504-5506 (800) 292-8064 (360) 586-5299 fax

How do I request a Limitation Extension?

Write/Call:

Division of Health Services Quality Support Quality Utilization Section Durable Medical Equipment PO Box 45506 Olympia, WA 98504-5506 (800) 292-8064 (360) 586-5299 fax

Where do I address reimbursement issues, questions, or comments?

DME - Program Manager Professional Rates Section Division of Operational Support Services PO Box 45510 Olympia, WA 98504-5510

Where do I call if I have questions regarding electronic billing?

Write/call:

Electronic Billing Unit PO Box 45512 Olympia, WA 98504-5512 (360) 725-1267

Important Contacts (cont.)

<u>How do I obtain copies of billing</u> instructions or numbered memoranda?

Check out our web site at:

http://maa.dshs.wa.gov

Or write/call:

Provider Relations Unit PO Box 45562 Olympia WA 98504-5562 (800) 562-6188

Who do I contact if I have questions regarding...

<u>Payments, denials, general questions</u> <u>regarding claims processing, or Healthy</u> <u>Options?</u>

Provider Relations Unit (800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Coordination of Benefits Section (800) 562-6136

Definitions

This section defines terms and acronyms used in these billing instructions.

Artificial limb – See prosthetic device. [WAC 388-543-1000]

By Report (BR) – A method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees. [WAC 388-543-1000]

Client - An applicant for, or recipient of, DSHS medical care program.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the department that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Date of Delivery – The date the client actually took physical possession of an item or equipment. [WAC 388-543-1000]

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Expedited Prior Authorization – The process for obtaining authorization for selected durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications/conditions/MAA-defined criteria are applicable to a particular request for DME authorization. [WAC 388-543-1000]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance Advice and Status Report (RA) that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fee-for-Service – The general payment method MAA uses to reimburse for covered medical services provided to clients, except those services covered under MAA's prepaid managed care programs.

[WAC 388-543-1000]

Health Care Financing Administration Common Procedure Coding System (HCPCS) – A coding system established by the Health Care Financing Administration to define services and procedures. [WAC 388-543-1000] Internal Control Number (ICN) - A 17-digit number that appears on your Remittance Advice and Status Report (RA) by the client's name. Each claim is assigned an ICN when it is received by MAA. The number identifies that claim throughout the claim's history.

Limitation Extension – A process for requesting and approving covered services and reimbursement that exceeds a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization. [WAC 388-543-1000]

Managed Care - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
[WAC 388-538-050]

Maximum Allowable - The maximum dollar amount for which a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federally funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the statefunded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Identification card(s) – Medical Identification cards are the forms DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

Medical Management, Division of (DMM)

- A division within the Medical Assistance Administration responsible for the administration of the quality improvement and assurance programs, utilization review and management, and prior authorization for fee-for-service program.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Orthotic Device or Orthotic – A corrective or supportive device that:

- Prevents or corrects physical deformity or malfunction; or
- Supports a weak or deformed portion of the body. [WAC 388-543-1000]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Prior Authorization – A process by which clients or providers must request and receive MAA approval for certain medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are types of prior authorization. Also see WAC 388-501-0165.
[WAC 388-543-1000]

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts; and
- Provider Enrollment/Relations

Prosthetic device or prosthetic – A replacement, corrective, or supportive device prescribed by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice as defined by state law, to:

- Artificially replace a missing portion of the body;
- Prevent or correct physical deformity or malfunction; or
- Support a weak or deformed portion of the body. [WAC 388-543-1000]

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. [WAC 388-500-0005]

Remittance Advice and Status Report (Referred to as "RAs")- A report produced by the Medicaid Management Information System (MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Resource Based Relative Value Scale (**RBRVS**) – A scale that measures the relative value of a medical service or intervention, based on amount of physician resources involved. [WAC 388-543-1000]

Revised Code Of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client.

Usual and Customary Charge – The amount the provider typically charges to 50% or more of his or her non-Medicaid clients, including clients with other third-party coverage. [WAC 388-543-1000]

Washington Administrative Code (WAC) - Codified rules of the State of Washington.

About the Program

What is the purpose of the Prosthetic and Orthotic Devices program? (Refer to WAC 388-543-1100)

The Medical Assistance Administration's (MAA) Prosthetic and Orthotic (P&O) Devices program makes the purchase of medically necessary P&O devices accessible to eligible MAA clients when the P&O devices are not included in other reimbursement methodologies (e.g., inpatient hospital DRG, nursing facility daily rate, HMO, or managed health care programs). The federal government deems P&O devices as optional services under the Medicaid program, except when:

- Prescribed as an integral part of an approved plan of treatment under the Home Health program; or
- Required under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program.

Notifying Clients of Their Rights (Advance Directives) (42 CFR, Subpart I)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give <u>all adult clients</u> written information about their right, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Prosthetic and Orthotic Devices

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Client Eligibility

Who is eligible for P&O Devices? (Refer to Chapter 388-529 WAC)

Clients presenting Medical Identification cards with the following identifiers* <u>are eligible</u> for P&O devices:

Medical Program Identifier Medical Program CNP Categorically Needy Program – These clients are dual eligible (Medicare/Medicaid) **CNP** Categorically Needy Program - Children's Children's Health Health **CNP** Categorically Needy Program - Children's Health Insurance Program **CHIP GA-U** General Assistance - Unemployable No Out of State Care **LCP** Limited Casualty Program-Medically Needy **MNP** Program **MNP** Medically Needy Program-Qualified Medicare Beneficiaries – These clients are **QMB**



Note: To clarify, clients presenting Medical ID cards with the following identifiers are not eligible for P&O devices:

✓ **QMB-Medicare Only** (Qualified Medicare Beneficiary-Medicare Only) (See *Billing* section)

dual eligible (Medicare/Medicaid)

✓ MIP-EMER Hospital Only – No out-of-state care (Medically Indigent Program-EMER Hospital Only – No out-of-state care)

Are clients enrolled in Healthy Options managed care eligible for P&O devices? (Refer to WAC 388-538-060 and 095)

YES! Clients with an identifier in the HMO column on their Medical Identification card are enrolled in one of MAA's Healthy Options managed care plans. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their PCP by calling the telephone number located on their Medical Identification card.

All medical services covered under a managed health care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

To prevent billing denials, please check the client's Medical Identification card <u>prior</u> to scheduling services and at the <u>time of service</u> to make sure proper authorization or referral is obtained from the PCP and/or plan.

MAA does not cover P&O devices provided by a nonparticipating provider for a client who is enrolled in a MAA-contracted managed care plan. (Refer to WAC 388-543-1400 [9])

Are clients enrolled in Primary Care Case Manager/Management (PCCM) eligible for P&O devices?

Yes! For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column will be "PCCM." These clients must obtain or be referred for services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's Medical Identification card for the PCCM. (See the *Billing* section for further information.)



Note: To prevent billing denials, please check the client's Medical Identification card <u>prior</u> to scheduling services and at the <u>time of the service</u> to make sure proper authorization or referral is obtain from the PCCM.

Coverage

What is covered? (Refer to WAC 388-543-1100)

- The Medical Assistance Administration (MAA) covers the P&O devices, repairs, and labor charges listed in the *Fee Schedule* (section H) of this billing instruction.
- MAA covers a replacement prosthesis only when the purchase of a replacement prosthesis is less costly than repairing or modifying a client's current prosthesis.
 (WAC 388-543-2600[3])

What are the general conditions of coverage?

(Refer to WAC 388-543-1100)

MAA covers the P&O devices listed in the *Fee Schedule* (section H) of this billing instruction when all of the following apply. The P&O devices must be:

- Medically necessary (see *Definitions* section). The provider or client must submit sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:
 - A physiological description of the client's disease, injury, impairment, or other ailment, and any changes in the client's condition written by the prescribing physician, licensed prosthetist and/or orthotist, physical therapist, occupational therapist, or speech therapist; or
 - Video and/or photograph(s) of the client demonstrating the impairments and the client's ability to use the requested equipment, when applicable.
- Within the scope of an eligible client's medical care program (see *Client Eligibility* section);
- Within accepted medical or physical medicine community standards of practice;
- Prior authorized (see *Authorization* section);
- Prescribed by a physician or other licensed practitioner of the healing arts and within the scope of his or her practice as defined by state law. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being reevaluated), and quantity; and

• Billed to the department as the payer of last resort only. MAA does not pay first and then collect from Medicare.



Note: MAA evaluates By Report (BR) items, procedures, or services for medical appropriateness and reimbursement value on a case-by-case basis.

What if a service is covered but considered experimental or has restrictions or limitations? (Refer to WAC 388-543-1100 [3] and [4])

- MAA evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational as defined by WAC 388-531-0050, under the provisions of WAC 388-501-0165 which relate to medical necessity.
- MAA evaluates a request for a covered service that is subject to limitations or other restrictions and approves such a service beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165 (see page F.3 for limitation extensions).

How can I request that equipment/supplies be added to the "covered" list in this billing instruction? (WAC 388-543-1100 [7])

An interested party may request MAA to include new P&O devices and related supplies and services in these billing instructions by sending a written request to MAA's Quality Utilization Section (see *Important Contacts* section), plus all of the following:

- Manufacturer's literature;
- Manufacturer's pricing;
- Clinical research/case studies (including FDA approval, if required); and
- Any additional information the requestor feels is important.

What is not covered? (Refer to WAC 388-543-1300)

MAA pays only for P&O devices and related supplies and services that are medically necessary, listed as covered, meet the definition of prosthetics and orthotics (see *Definitions* section), and prescribed per the provider requirements in this billing instruction (see *Provider Requirements* section).

MAA considers all requests for covered P&O devices and related supplies and services, and noncovered P&O devices and related supplies and services, under the provisions of WAC 388-501-0165 which relate to medical necessity. When MAA considers that a request does not meet the requirements for medical necessity, the definition(s) of covered item(s), or is not covered, the client may appeal that decision under the provisions of WAC 388-501-0165.

MAA specifically excludes services and equipment in this billing instruction from fee-for-service (FFS) scope of coverage when the services and equipment do not meet the definition for a covered item, or the services are not typically medically necessary. This exclusion does not apply if the services and equipment are:

- Required under the EPSDT program;
- Included as part of a managed care plan service package;
- Included in a waivered program; or
- Part of one of the Medicare programs for qualified Medicare beneficiaries.

Services and equipment that are not covered include, but are not limited to:

- Services, procedures, devices, or the application of associated services that the Food and Drug Administration (FDA) and/or the Centers for Medicare and Medicaid Services (CMS) (formerly known as Health Care Financing Administration [HCFA]) consider investigative or experimental on the date the services are provided;
- Any service specifically excluded by statute;
- More costly services or equipment when MAA determines that less costly, equally effective services or equipment are available;
- Hairpieces or wigs;
- Material or services covered under manufacturer's warranties;
- Procedures, prosthetics, or supplies related to gender dysphoria surgery;
- Shoe lifts less than one inch, arch supports, and nonorthopedic shoes;
- Supplies and equipment used during a physician office visit, such as tongue depressors and surgical gloves;

- Prosthetic devices dispensed for cosmetic reasons;
- Personal and comfort items that do not meet the definition of a prosthetic or orthotic device (see *Definitions* section), including, but not limited to, the following:
 - Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, and socks;
 - ✓ Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, commercial sun screens, and tanning; and
 - ✓ Impotence devices;



Note: MAA evaluates a request for any equipment or devices that are listed as noncovered in this billing instruction under the provisions of WAC 388-501-0165. (Refer to WAC 388-543-1100[2])

Provider Requirements

What is required from MAA's P&O devices providers? (Refer to WAC 388-543-1200 [1])

MAA requires a provider who supplies P&O devices and related supplies and services to an MAA client to meet all of the following. The provider must:

- Have a proper business license;
- Have appropriately trained qualified staff;
- Be certified, licensed, and/or bonded, if required, to perform the services billed to MAA. Out-of-state P&O providers must meet their state regulatory requirements; and
- Have an MAA core provider agreement.

Who does MAA reimburse for providing P&O devices and related supplies and services to MAA clients?

(Refer to WAC 388-543-1200 [2])

MAA may reimburse qualified providers for P&O devices, repairs, and related supplies and services on a fee-for-service (FFS) basis as follows:

- Licensed P&O providers who are licensed by the Washington State Department of Health (DOH) in P&O. This does not apply to medical equipment dealers and pharmacies that do not require licensure to provide selected P&O;
- Physicians who provide medical equipment and supplies in the physician's office. MAA
 may pay separately for medical supplies, subject to the provisions in MAA's Physician'sRelated Services (RBRVS) fee schedule; and
- Out-of-state P&O providers who meet their state regulations.



Note: MAA terminates from Medicaid participation any provider who violates program regulations and policies, as described in WAC 388-502-0030. (WAC 388-543-1200 [3])

What records must be kept? (Refer to WAC 388-502-0020)

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:
 - ✓ Patient's name and date of birth;
 - ✓ Dates of service(s);
 - ✓ Name and title of person performing the service, if other than the billing practitioner;
 - ✓ Chief complaint or reason for each visit;
 - ✓ Pertinent medical history;
 - ✓ Pertinent findings on examination;
 - ✓ Medications, equipment, and/or supplies prescribed or provided;
 - ✓ Description of treatment (when applicable);
 - ✓ Recommendations for additional treatments, procedures, or consultations;
 - ✓ X-rays, tests, and results;
 - ✓ Plan of treatment and/or care, and outcome;
 - ✓ Specific claims and payments received for services; and
 - ✓ Any specifically required forms for the provision of P&O devices.
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.
- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, <u>for at least six years from the date of service</u> or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (Refer to WAC 388-502-0020[2])

Authorization

What is prior authorization?

Prior authorization (PA) is MAA's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization (EPA) and limitation extensions (LE) are forms of prior authorization.**

Is Prior Authorization required? (Refer to WAC 388-543-1600)

Yes! The Medical Assistance Administration (MAA) requires prior authorization for certain purchases and repairs of medically necessary P&O devices and related supplies and services. Please refer to the PA column of the *Fee Schedule* (Section H) for items that require prior authorization.

MAA bases its determination about which P&O devices and related supplies and services require PA or EPA on utilization criteria. MAA considers all of the following when establishing utilization criteria:

- High cost;
- Potential for utilization abuse;
- Narrow therapeutic indication; and
- Safety.

How do I request prior authorization?

Providers must submit the request in writing to the Quality Utilization Section or call the authorization toll-free number at 1-800-292-8064. (See *Important Contacts* section.)

General Policies for Prior Authorization

(Refer to WAC 388-543-1800)

• For PA requests, MAA requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification identified as a separate charge. MAA does not accept general standards of care or industry standards for generalized equipment as justification.

- When MAA receives an initial request for PA, the prescription(s) for those items or services cannot be older than three months from the date MAA receives the request.
- MAA requires certain information from providers to prior authorize the purchase of equipment. This information includes, but is not limited to, the following:
 - ✓ A detailed description of the item; and
 - ✓ Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.
- MAA prior authorizes By Report (BR) items that require PA and are listed in the *Fee Schedule* (section H) only if medical necessity is established and the provider furnishes all of the following information to MAA:
 - ✓ A detailed description of the item or service to be provided;
 - ✓ The cost or charge for the item;
 - ✓ A copy of the manufacturer's invoice, price-list or catalog with the product description for the item being provided; and
 - ✓ A detailed explanation of how the requested item differs from an already existing code description.
- MAA does not reimburse for purchase or repair of medical equipment that duplicates equipment the client already owns. If the provider makes such a request, MAA requires the provider to submit a PA request and explain the following:
 - ✓ Why the existing equipment no longer meets the client's medical needs; or
 - ✓ Why the existing equipment could not be repaired or modified to meet those medical needs.
- A provider may resubmit a request for PA for an item or service that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.
- MAA prior authorizes extensive maintenance that the manufacturer recommends be performed by an authorized dealer. MAA requires the client to take responsibility for routine maintenance of a prosthetic or orthotic. If the client does not have the physical or mental ability to perform the task, MAA requires the client's caregiver to be responsible. [WAC 388-543-2600 (4)]



Note: Written requests for prior authorization must be submitted to MAA on a HCFA-1500 claim form with the date of service left blank and a copy of the prescription attached.

What is a limitation extension?

A limitation extension is when MAA allows additional units of service for a client when the provider can verify that the additional units of service are medically necessary. Limitation extensions require prior authorization.

Note: Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all client eligibility groups cover all services.

How do I request a limitation extension?

In cases where the provider feels that additional services are medically necessary for the client, the provider must request pre-approval from MAA in writing.

The request must state the following in writing:

- 1. The name and PIC number of the client;
- 2. The provider's name, provider number and fax number;
- 3. Additional service(s) requested;
- 4. Copy of last prescription and date dispensed;
- 5. The primary diagnosis code and HCPCS code or state assigned code; and
- 6. Client-specific clinical justification for additional services.

Send your request for a limitation extension to:

Division of Health Services Quality Support Quality Utilization Section Durable Medical Equipment/P&O Devices PO Box 45506 Olympia, WA 98504-5506 (800) 292-8064 (360) 586-5299 fax

What is expedited prior authorization?

The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected P&O device procedure codes. MAA allows payment during a continuous 12-month period for this process.

To bill MAA for P&O devices that meet the EPA criteria on the following pages, the provider must create a 9-digit EPA number. The first 6 digits of the EPA number must be **870000**. The last 3 digits must be the code number of the product and documented medical condition that meets the EPA criteria. Enter the EPA number on the HCFA-1500 claim form in the *Authorization Number* field or in the *Authorization* field when billing electronically.

Example: The 9-digit EPA number for purchase of a foot insert, removable, formed to patient foot for a client that meets one of the EPA criteria would be **870000780** (870000 = first 6 digits, 780 = product and documented medical condition).

Providers are reminded that EPA numbers are only for those products listed on the EPA Criteria Coding List. EPA numbers are not valid for:

- P&O devices requiring prior authorization through the P&O Devices program;
- Products for which the documented medical condition does not meet <u>all</u> of the specified EPA criteria; or
- Over-limitation requests.

The written or telephonic request process for PA must be used when a situation does not meet the criteria for EPA for a selected P&O device procedure code. Providers must submit the request in writing to the Quality Utilization Section or call the authorization toll-free number at 1-800-292-8064. (See *Important Contacts* section.) (Refer to WAC 388-543-1900[3])

Expedited Prior Authorization Guidelines:

- **A. Medical Justification (criteria)** All information must come from the client's prescribing physician or therapist, with an appropriately completed prescription. MAA does not accept information obtained from the client or from someone on behalf of the client (e.g. family).
- **B. Documentation** The billing provider **must keep** documentation of the criteria in the client's file. Upon request, a provider must provide documentation to MAA showing how the client's condition met the criteria for EPA. Keep documentation file for six (6) years. (Refer to WAC 388-543-1900[4])



Note: MAA may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria. Refer to WAC 388-502-0100. (WAC 388-543-1900[5])

EPA Criteria Coding List

Code Criteria Code Criteria

PROSTHETICS

Procedure Code: L5669/L5667

787 Addition to lower extremity, below knee/above knee, socket insert, suction suspension with or without locking mechanism.

Purchase of one (1) L5669 and L5667 per initial, lower extremity prosthesis (one to wash, one to wear) allowed per 12-month period if any of the following criteria are met:

- 1) Short residual limb;
- 2) Diabetic; or
- 3) History of skin problems/open sores on stump.

☞ NOTE:

- 1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
- 2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.
- 3) EPA is for initial purchase only. It is not to be used for replacements of existing products.

ORTHOTICS

Procedure Code: L3030

Foot insert, removable, formed to patient foot.

One (1) pair allowed in a 12-month period if one of the following criteria is met:

- 1) Severe arthritis with pain;
- 2) Flat feet or pes planus with pain;
- 3) Valgus or varus deformity with pain;
- 4) Plantar facitis with pain; or
- 5) Pronation.

☞ NOTE:

- 1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
- 2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

Procedure Code: 3300L

781 Lift, elevation, heel & sole, per inch.

Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.

Procedure Code: L3334

782 Lift, elevation, heel, per inch

Allowed for as many inches as required (has to be at least one inch), for a client with a leg length discrepancy, on one shoe per 12-month period.

NOTE (for 3300l and L3334):

- 1) Lifts are not covered for less than one (1) inch
- 2) Lifts are only allowed on one (1) pair of client shoes.
- 3) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
- 4) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

Procedure Code: L3000

784 Foot insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each

Purchase of one (1) pair per 12-month period for a client 16 years of age or younger allowed if any of the following criteria are met:

- 1) Required to prevent or correct pronation;
- 2) Required to promote proper foot alignment due to pronation; or
- 3) For ankle stability as required due to an existing medical condition such as hypotonia, Cerebral Palsy, etc.

™ NOTE:

- 1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
- 2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.
- 3) If the client only medically requires one orthotic, right or left, prior authorization must be obtained.

Procedure Code: L3215 or L3219

785 Orthopedic footwear, woman's or man's shoes, oxford.

Purchase of one (1) pair per 12-month period allowed if any of the following criteria are met:

- 1) When one or both shoes are attached to a brace:
- 2) When one or both shoes are required to accommodate a brace with the exception of L3030 foot inserts:
- 3) To accommodate a partial foot prosthesis; or
- 4) To accommodate club foot.

☞ NOTE:

- 1) MAA does not allow orthopedic footwear for the following reasons:
 - a) To accommodate L3030 orthotics;
 - b) Bunions;
 - c) Hammer toes;
 - d) Size difference (mismatched shoes); or
 - e) Abnormal sized foot.

Continued on next page **►**

- 2) MAA only allows the following manufacturers of Orthopedic:
 - a) Acor;
 - b) Alden Shoe Company;
 - c) Jerry Miller;
 - d) Markell;
 - e) P.W. Minor;
 - f) Walkin-Comfort; and
 - g) Hanger.
- 3) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
- 4) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

Procedure Code: L1945

786 AFO, molded to patient model, plastic, rigid anterior tibial section (floor reaction).

Purchase of one per limb allowed per 12-month period if <u>all</u> of the following criteria are met:

- 1) Client is 16 years old or younger; and
- 2) Required due to a medical condition causing crouched gait.

☞ NOTE:

- 1) If the medical condition does not meet one of the above specified criteria, you must obtain prior authorization by submitting a request in writing to QUS (see *Important Contacts*) or by calling the authorization toll-free number at 1-800-292-8064.
- 2) EPA is allowed only one time per client, per 12-month period. It is the provider's responsibility to determine whether the client has already used all EPA in the period allowed under the EPA criteria.

Prosthetic and Orthotic Devices

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Reimbursement

General Reimbursement for P&O Devices and Related Supplies and Services (Refer to WAC 388-543-1400 and 388-543-2700)

- MAA reimburses a qualified provider who serves a client who is not enrolled in a department-contracted managed care plan only when all of the following apply:
 - ✓ The provider meets all of the conditions in WAC 388-502-0100; and
 - ✓ MAA does not include the item/service for which the provider is requesting reimbursement in other reimbursement rate methodologies. Other methodologies include, but are not limited to, the following:
 - ➤ Hospice providers' per diem reimbursement;
 - Hospital's diagnosis related group (DRG) reimbursement;
 - Managed care plans' capitation rate; and
 - Nursing facilities' per diem rate.
- A provider must not bill MAA for the purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.
- Reimbursement for P&O devices is limited to HCPCS/National Codes with the same level of coverage as Medicare.
- MAA may adopt policies, procedure codes, and/or rates that are different than those set by Medicare, if MAA determines that such actions are in the best interest of its clients.
- MAA may pay for medical services rendered to a client only when MAA is the payer of last resort.
- MAA's maximum payment for medical equipment and supplies is the lesser of either of the following:
 - ✓ Provider's usual and customary charge; or
 - ✓ Established rates, unless the client is eligible for both Medicare and Medicaid (see *Billing* section).

- MAA determines reimbursement for P&O devices according to a set fee schedule (see section H). MAA considers Medicare's current fee schedule when determining maximum allowable fees. For By Report (BR) codes, MAA reimburses 85% of the agreed upon fee.
- MAA sets maximum allowable fees for P&O devices and related supplies and services using available published information, such as:
 - ✓ Commercial databases for price comparisons;
 - ✓ Manufacturers' catalogs;
 - ✓ Medicare fee schedules; and
 - ✓ Wholesale prices.
- MAA evaluates and updates the maximum allowable fees for P&O devices at least once per year, independent of scheduled legislatively authorized vendor rate increases. Rates remain effective until the next rate change.

Specific Reimbursement for P&O Devices

(Refer to WAC 388-543-2700)

- MAA's reimbursement for a P&O device includes the cost of any necessary molds.
- MAA's hospital reimbursement rate includes any P&O devices required for surgery and/or placed during the hospital stay.
- Reimbursement for gender dysphoria surgery includes payment for all related prosthetics and supplies.

Purchased P&O Devices and Related Supplies

(Refer to WAC 388-543-1500)

- P&O devices and related supplies that MAA purchases for a client are the client's property. MAA reimbursement for covered P&O devices and related supplies includes all of the following:
 - ✓ Any adjustments or modifications to the equipment that are required within three months of the date of delivery. This does not apply to adjustments required because of changes in the client's medical condition;
 - ✓ Fitting and set-up; and
 - ✓ Instruction to the client or client's caregiver in the appropriate use of the equipment, device, and/or supplies.

- MAA requires a provider to furnish to MAA clients only new equipment that includes full manufacturer and dealer warranties.
- MAA charges the dispensing provider for any costs it incurs to have another provider repair equipment if all of the following apply:
 - ✓ The dispensing provider is unwilling or unable to fulfill the warranty; and
 - ✓ The client still needs the equipment.
- MAA rescinds purchase orders for the following reasons:
 - ✓ If the equipment was not delivered to the client before the client:
 - > Dies;
 - Loses medical eligibility;
 - **>** Becomes covered by a hospice agency; or
 - Becomes covered by an MAA managed care plan.
 - A provider may incur extra costs for customized equipment that may not be easily resold. In these cases, for purchase orders rescinded per the stipulations listed above, MAA may pay the provider an amount it considers appropriate to help defray these extra costs. MAA requires the provider to submit justification sufficient to support such a claim.
 - ✓ A client may become a managed care plan client before MAA completes the purchase of prescribed medical equipment. If this occurs:
 - MAA rescinds the purchase order until the managed care primary care provider (PCP) evaluates the client; then
 - MAA requires the PCP to write a new prescription if the PCP determines the equipment is still medically necessary (see *Definitions* section); then
 - The managed care plan's applicable reimbursement policies apply to the purchase or rental of the equipment.



Note: P&O devices placed during an inpatient hospital stay **are** included in the hospital reimbursement rate. MAA does **not** reimburse separately under these circumstances.

Prosthetic and Orthotic Devices

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Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

- MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.
- The provider must submit claims as described in MAA's billing instructions.
- MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:
 - ✓ The date the provider furnishes the service to the eligible client;
 - ✓ The date a final fair hearing decision is entered that impacts the particular claim;
 - ✓ The date a court orders MAA to cover the services; or
 - ✓ The date DSHS certifies a client eligible under delayed¹ certification criteria.
- MAA may grant exceptions to the 365 billing day time limit for **initial claims** when billing delays are caused by either of the following:
 - ✓ DSHS certification of a client for a retroactive² period; or
 - ✓ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

Delayed Certification - According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, the provider must not bill, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and must promptly refund the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), the provider must not bill, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and must promptly refund the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Retroactive Certification - According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, the provider must not bill, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; and may refund any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

• Providers may **resubmit, modify, or adjust** any timely initial claim, <u>except prescription</u> drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.



Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.
- The provider, or any agent of the provider, must not bill a client or a client's estate when:
 - ✓ The provider fails to meet these listed requirements; and
 - ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee.



Exception: If billing Medicare Part B crossover claims, bill the amount

submitted to Medicare.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and
- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

How do I bill for clients who are eligible for Medicare and Medical Assistance?

If a client is eligible for both Medicare and Medical Assistance (otherwise known as "dualeligible"), you must <u>first</u> submit a claim to Medicare and accept assignment within Medicare's time limitations. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claim (see page I.1).
- Codes billed to MAA must match codes billed to Medicare when billed as a Medicare Part B crossover claim.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words "This information is being sent to either a private insurer or Medicaid fiscal agent," appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance Advice and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit an HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment or a denial.
- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment or a denial.
- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

Note:

- ✓ Medicare/Medical Assistance billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.
- ✓ A Medicare Remittance Notice or EOMB must be attached to each claim

Payment Methodology - Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)
- Medicare's payment is deducted from the amount selected above.
- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.
- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

- 1) The provider <u>accepts</u> assignment; and
- 2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Identification card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance Advice and Status Report (RA) for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA RA showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the *Comments* field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

Prosthetic and Orthotic Devices

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How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!General Guidelines:

• Use only the original preprinted red and white HCFA-1500 claim forms (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner <u>cannot read</u> black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

If you need preprinted red and white HCFA-1500 claim forms, call 1-800-562-6188.

- Do not use red ink pens, highlighters, "post-it notes," or stickers anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.
- Use standard typewritten fonts that are 10 c.p.i (characters per inch).

 Do not mix character fonts on the same claim form. Do not use italics or script.
- Use upper case (capital letters) for all alpha characters.
- Use black printer ribbon, ink-jet, or laser printer cartridges.
- Ensure all the claim information is entirely contained within the proper field on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- Place only six detail lines on each claim form. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.
- Show the total amount for each claim form separately. Do not indicate the entire total (for all claims) on the last claim form; total each claim form.

Field Description/Instructions

- 1a. <u>Insured's I.D. No.</u>: Required. Enter the MAA Patient (client) Identification Code (PIC). This information is obtained from the client's current monthly Medical Identification card and consists of the client's:
 - a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
 - b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
 - c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder <u>before</u> adding the tie breaker.
 - d) An alpha or numeric character (tie breaker).

For example:

- 1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- 2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
- 3. A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB and would show a **B** indicator in *field* 19.
- 2. <u>Patient's Name</u>: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).
- **3. Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

- 4. <u>Insured's Name (Last Name, First Name, Middle Initial)</u>: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same then the word *Same* may be entered.
- 5. <u>Patient's Address</u>: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field* 2.)
- 9. Other Insured's Name: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.
- **9a**. Enter the other insured's policy or group number *and* his/her Social Security Number.
- **9b** Enter the other insured's date of birth.
- **9c**. Enter the other insured's employer's name or school name.
- **9d.** Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are <u>inappropriate</u> entries for this field.

- 10. <u>Is Patient's Condition Related To</u>:
 Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. *Indicate the name of the coverage source in field 10d* (L&I, name of insurance company, etc.).
- 11. Insured's Policy Group or FECA
 (Federal Employees Compensation
 Act) Number: Primary insurance.
 When applicable. This information
 applies to the insured person listed in
 field 4. Enter the insured's policy
 and/or group number and his/her social
 security number. The data in this field
 will indicate that the client has other
 insurance coverage and MAA pays as
 payor of last resort.
- **11a.** <u>Insured's Date of Birth</u>: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.
- 11b. Employer's Name or School Name: Primary insurance. When applicable, enter the insured's employer's name or school name.
- 11c. <u>Insurance Plan Name or Program</u>
 <u>Name</u>: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. (Note: This may or may not be associated with a group plan.)

11d. Is There Another Health Benefit Plan?: Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If

11d. is left blank, the claim may be processed and denied in error.

- 17. Name of Referring Physician or Other Source: When applicable, enter the referring physician or Primary Care Case Manager name.
- 17a. I.D. Number of Referring Physician:
 When applicable, 1) enter the sevendigit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.
- 19. Reserved For Local Use: When applicable, enter indicator B to indicate Baby on Parent's PIC. Please specify twin A or B, triplet A, B, or C here.
- 21. <u>Diagnosis or Nature of Illness or Injury</u>: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4. A valid ICD-9-CM code will be required. MAA no longer allows the use of an unspecified/dummy diagnosis code such as V58.9.

- 22. <u>Medicaid Resubmission</u>: When applicable. If the billing is resubmitted beyond the 365-day billing time limit, you must enter the ICN to verify that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)
- 23. <u>Prior Authorization/EPA Number</u>: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you. <u>Use only one</u> authorization number per claim.
- 24. Enter only one (1) procedure code per detail line (fields 24A 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.

MAA does not accept "continued" claim forms. Each claim form must be totaled separately.

24A. <u>Date(s) of Service</u>: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., November 4, 2001 = 110402). **Do not use slashes, dashes, or hyphens to separate month, day, year.**

24B. <u>Place of Service</u>: Required. These are the only appropriate code(s) for this billing instruction:

Code Number To Be Used For

4	Client's residence
7	Nursing facility
	(formerly
	ICF)
8	Nursing facility
	(formerly
	SNF)
9	Other

- **24C.** Type of Service: Required. Enter a 9.
- 24D. Procedures, Services or Supplies
 HCPCS: Required. Enter the appropriate Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) Common Procedure Coding System (HCPCS) or state-unique procedure code for the services being billed. MODIFIER: When appropriate enter a modifier.
- 24E. <u>Diagnosis Code</u>: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM. A valid ICD-9-CM code is required. MAA no longer allows the use of an unspecified/dummy diagnosis code such as V58.9.

- 24F. <u>\$ Charges</u>: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.
- **24G.** <u>Days or Units</u>: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.
- 25. <u>Federal Tax I.D. Number</u>: Leave this field blank.
- 26. Your Patient's Account No.: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance Advice and Status Report (RA) under the heading Patient Account Number.
- **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.
 - MAA does not accept "continued" claim forms. Each claim form must be totaled separately.
- 29. Amount Paid: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

- **30.** Balance Due: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.
- 33. Physician's, Supplier's Billing
 Name, Address, Zip Code and
 Phone #: Required. Put the Name,
 Address, and Phone # on all claim
 forms.
 - **P.I.N. #:** Required. Enter the individual provider number assigned to you by MAA.

Prosthetic and Orthotic Devices

Sample HCFA-1500 Form

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO" in black ink in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment. Use black ink for the "XO" in box 19 on crossover claims.

Q: What fields do I use for HCFA-1500 Medicare information?

A:	In Field:	Please Enter:
19 an "XO"		an "XO"
24K Medicare's allowed charges		Medicare's allowed charges
	29	Medicare's total deductible
	30 Medicare's total payment	
	32	Medicare's EOMB process date, and the third-party
		liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach Medicaid after I've sent them to Medicare?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the remarks code is, "MA07-The claim information has also been forwarded to Medicaid for review," it means that your claim has been forwarded to MAA.

Q: What if my claim(s) does not appear on the RA?

A: If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance Advice and Status Report (RA) within 45 days of the Medicare statement date, you should bill MAA the *paid lines* on the HCFA-1500 claim form **with** an "XO" in box 19.

If **Medicare denies** a service, bill MAA the <u>denied lines</u>, using the HCFA-1500 claim form **without** an "XO" on the claim.

REMEMBER! Attach a copy of Medicare's EOMB.

REMEMBER! You must submit your claim to MAA within six months of the Medicare statement date if Medicare has **paid** or 365 days from date of service if Medicare has **denied**.



Note: Claims billed to MAA with payment by Medicare must be submitted with the same procedure code used to bill Medicare.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.



General Guidelines:

• Use only the original preprinted red and white HCFA-1500 claim forms (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner <u>cannot read</u> black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

If you need preprinted red and white HCFA-1500 claim forms, call 1-800-562-6188.

- **Do not use red ink pens, highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.
- Use standard typewritten fonts that are 10 c.p.i (characters per inch).

 Do not mix character fonts on the same claim form. Do not use italics or script.
- Use upper case (capital letters) for all alpha characters.
- Use black printer ribbon, ink-jet, or laser printer cartridges.
- Ensure all the claim information is entirely contained within the proper field on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- Place only six detail lines on each claim form. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.
- Show the total amount for each claim form separately. Do not indicate the entire total (for all claims) on the last claim form; total each claim form.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, <u>cannot</u> be billed electronically.

FIELD DESCRIPTION

- 1a. <u>Insured's I.D. No.</u>: Required. Enter the MAA Patient Identification Code (PIC). This information is obtained from the client's current monthly Medical Identification card and consists of the client's:
 - First and middle initials (a dash
 [-] must be used if the middle initial is not available).
 - Six-digit birthdate, consisting of *numerals only* (MMDDYY).
 - First five letters of the last name.
 If there are fewer than five letters in the last name, leave spaces for the remainder <u>before</u> adding the tiebreaker.
 - An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B
- 2. <u>Patient's Name</u>: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

- 3. <u>Patient's Birthdate</u>: Required. Enter the birthdate of the MAA client.
- 4. Insured's Name (Last Name, First Name, Middle Initial): When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same then the word *Same* may be entered.
- 5. <u>Patient's Address</u>: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).
- 9. Other Insured's Name: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.
- **9a.** Enter the other insured's policy or group number *and* his/her Social Security Number.
- **9b**. Enter the other insured's date of birth.
- **9c**. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are <u>inappropriate</u> entries for this field.

- 10. <u>Is Patient's Condition Related To:</u>
 Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24. Indicate the name of the coverage source in field 10d* (L&I, name of insurance company, etc.).
- 11. Insured's Policy Group or FECA
 (Federal Employees Compensation
 Act) Number: Primary insurance.
 When applicable. This information applies to the insured person listed in field 4. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payer of last resort.
- 11a. <u>Insured's Date of Birth</u>:
 Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.
- 11b. Employer's Name or School Name:
 Primary insurance. When
 applicable, enter the insured's
 employer's name or school name.

- Name: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. (Note: This may or may not be associated with a group plan.)
- 11d. Is There Another Health Benefit Plan?: Required if the client has secondary insurance. Indicate yes or no. If yes, you should have completed fields 9a.-d. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check yes. If 11d. is left blank, the claim may be processed and denied in error.
- 19. Reserved For Local Use Required. When Medicare allows services, enter XO to indicate this is a crossover claim.
- 22. Medicaid Resubmission: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. [The ICN number is the *claim number* listed on the Remittance Advice and Status Report (RA).] Also enter the three-digit denial Explanation of Benefits (EOB).
- 24. Enter only one (1) procedure code per detail line (fields 24A 24K).

 If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form.

- 24A. <u>Date(s) of Service</u>: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., September 4, 2001 = 090401).

 Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).
- **24B.** Place of Service: Required. These are the only appropriate code(s) for this billing instruction:

<u>code</u>	<u>Number</u>	To Be Used For
4		Client's residence
7		Nursing facility
		(formerly ICF)
8		Nursing facility
		(formerly SNF)
9		Other

- **24C.** Type of Service: Required. Enter a 9.
- 24D. Procedures, Services or Supplies
 HCPCS: Required. Enter the
 appropriate HCFA Common Procedure
 Coding System (HCPCS) procedure
 code for the services being billed.
 MODIFIER: When appropriate enter
 a modifier.
- **24E.** <u>Diagnosis Code</u>: Enter appropriate diagnosis code for condition.
- 24F. <u>\$ Charges</u>: Required. <u>Enter the amount you billed Medicare for the service performed.</u> If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

- **24G.** <u>Days or Units</u>: Required. Enter the number of units billed and paid for by Medicare.
- **24K.** Reserved for Local Use: Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).
- 26. Your Patient's Account No.: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance Advice and Status Report (RA) under the heading Patient Account Number.
- 27. <u>Accept Assignment</u>: Required. Check yes.
- **28.** <u>Total Charge</u>: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.
- 29. Amount Paid: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Medicare Benefits (EOMB). If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. Do not include coinsurance here.

Medicare Total Payment. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Medicare Benefits (EOMB). If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. Do not include coinsurance here.

32. Name and Address of Facility Where Services Are Rendered:

Required. Enter Medicare Statement Date *and* any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. Physician's, Supplier's Billing
Name, Address, Zip Code and
Phone #: Required.

P.I.N. #: Required. Enter the individual provider number assigned to you by MAA.

	Prosthetic and Orthotic Devices
Sample Medicare Part B/Medica	uid Crossover Form
Sample Medicare Lart Biniedica	